Crisis Bed Development Work Group
May 24, 2006 10:00 – 12:00

Minutes

Next meeting: June 8, 2006 10:00 to 12:00 Location: ASSIST Program
300 Flynn Avenue, Burlington

Present: Jeff Rothenberg, CRT, CMC
Sheryl Bellman, Emergency, HCHS
John Stewart, CRT, RMHS
Sandy Smith, CRT, CSAC
Anne Donahue, Counterpoint
Graham Parker, HCRS
Isabelle Desjardins, FAHC/UVM ,

Staff: Judy Rosenstreich, VDH
Cindy Thomas, VDH

Agenda: Update of VSH Futures
Principles of a Hospital Diversion Bed program
Survey of Emergency Services and CRT directors at CMHC's
Next meeting planning and date

Jeff convened the meeting at 10:00 AM. Before turning to the agenda, the group heard from Dr. Isabelle Desjardins, Medical Director, Psychiatry, at Fletcher Allen Health Care. Dr. Desjardins joined the meeting by phone to share the perspective of FAHC's attending staff of physicians, social workers, and others with a range of responsibilities, including coordination of admissions and discharge planning for psychiatry services. The Fletcher Allen team agrees on the need for uniformity in development of the crisis bed program, citing vision, objectives and utilization as components that should be uniform across the system. Dr. Desjardins observed that there seems to be discrepancies in the mission of crisis diversion beds. For use as a step down function, the programs need psychiatric involvement. Areas most in need are the Northeast Kingdom, Franklin-Grand Isle, and Addison although Chittenden also would benefit from enhancement of current capacity. Allowing patients to step down closer to where they are going to receive their services would improve the quality of care in these areas. Dr. Desjardins clarified that the FAHC team's comments are not statistically driven.

Dr. Desjardins stated that the key is to bring uniformity to how crisis beds are used. The result would be clearer expectations when Fletcher Allen is dealing with multiple agencies. If you can bring uniformity, you can establish expectations for providing resources to support the system.

Further discussion covered these points:

- The group may have to define different levels / kinds of needs to be served by crisis bed programs. (Anne Donahue)
- An advantage of a community-based program is that they do not look or feel like a hospital. We would not want to give up anything we have now that works such as an observation bed that's ¼ way out of a hospital. (Graham Parker)
- Teleconferencing services offer potential for a psychiatrist to provide consultation to distant programs. (Anne)
- It is a very good idea to have psychiatric consultation with Emergency Department physicians if this capability is not yet in place. (Dr. Desjardins)
- Did the legislature envision a certain type of program? (John Stewart)
- The impression we had was that the new capacities would be similar to what we have now or connecting them to hospitals. (Jeff)

Anne responded that the Futures Plan identified five different potential models but that the mission and focus goes back to reducing the need for inpatient beds through preventing consumers from admissions to VSH in the first place or shortening length of stay (LOS).

Jeff summarized the discussion by stating that this work group's role is to recommend…

1) what we think is needed to augment current capacities
2) where the greatest need is (priority areas)
3) how much we think it will cost

Jeff explained that the assumption is the current beds are saving the system money because the consumers accessing crisis diversion beds would otherwise receive inpatient services.

The group found talking with Dr. Desjardins a useful way to gather information about Fletcher Allen's experience and perspective. It was decided to have a conversation with all the other hospitals, including VSH. Anne volunteered to speak with the other hospitals.

Minutes

Jeff distributed and reviewed the minutes of the first meeting on May 10th. There were no changes.

Principles (Program Guidelines) for Crisis Beds

Jeff presented some draft principles for discussion. The group added to and recast these program characteristics as follows. They are still considered a draft.

1) Voluntary: clients are admitted voluntarily
2) Medical oversight provided daily
3) Staff are specifically trained in: recovery, dual diagnosis treatment, family psycho-education and support, and trauma informed services

4) Peer services component (yet to be clarified)
5) Part of the larger care management system
6) Need to be fully funded (current Medicaid and other insurances do not reimburse crisis bed services)
7) Ensure that services are closer to a person's home
8) Divert from hospital admission or shorten length of stay
9) Facility has the right to decide, in the context of the care management system, who to accept for crisis diversion
10) Beds open to the greater need of the system but are intended to divert from inpatient care or reduce length of stay as a post-hospitalization component
11) Not limited to CRT clients
12) Daily access to a psychiatrist, if needed

Discussion around these core principles covered a number of areas, including…

Individual program choices: May a person exercise choice in the context of limited program availability? The voluntary nature of these programs does not mean that an individual can choose which crisis program to use based on a preference such as a smoking policy. In addition, to meet objectives, the program would have to be closest to a person's home.

Care management system: Crisis beds will be a component of the overall system for managing access and availability of acute care resources.

Peer services: The peer services component may be linked to Vermont Psychiatric Survivors (VPS).

Populations served: Crisis bed programs are intended for anyone who is clinically appropriate for this level of care; not just for clients of the CRT system. Therefore, we have to think programmatically about what is needed to serve a broader population.

Screeners' role: Screeners play a significant role in diversion recommendation.

Program size/capacity: Unless a program is associated with a hospital, you need 3-4 beds. A single-bed program could work if part of a hospital setting.

Daily psychiatric oversight: Given the reality that not every client needs to see a psychiatrist every day, the goal of "daily psychiatric oversight" should be *as needed.*

Medical oversight: How much nursing and staffing coverage has to be addressed.

Surveys of CRT and Emergency Services Directors

The work group agreed to create a survey for Emergency Service and CRT directors focusing on the needs of adults who were hospitalized over the past six months. Jeff distributed a draft survey. The group reviewed the content of the survey, deciding to ask not only for information gleaned from records over the last six months but also thoughts about what, in their opinion, would have the most impact on diverting inpatient hospital admissions. Jeff will send out the surveys and request them back by June 16th.

Next Meeting

The group agreed with Jeff's suggestion to talk with crisis bed programs as well as hospitals and, toward that end, to meet at a crisis bed program.

The next two meetings were scheduled:

JUNE 8 meeting at ASSIST, 300 Flynn Avenue, Burlington, from 10:00 to 12:00

JUNE 21 meeting at Home Intervention, 13 Kynoch Street, Barre, from 1:00 to 3:00

The meeting adjourned at 12:00 PM.

SUBMITTED BY: Judy Rosenstreich
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